Leveraging the Strengths of Two Sectors to Achieve Widespread Change in Health and Poverty

A Business Case for Integrated Microfinance and Health Programs

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We would like to acknowledge the authors of this paper: Marcia Metcalfe, former Senior Director of Microfinance and Health; Steve Hollingworth, President; and Kathleen Stack, Vice President of Programs, of Freedom from Hunger; and Myka Reinsch Sinclair, Advisor and Consultant.

This paper cites fieldwork and multiple evaluations of client and institutional impact from a range of programs initiated by Freedom from Hunger over the past eight years, and from other practitioners and researchers who are leading the growing movement to link financial services with other essential services needed by poor families to overcome poverty and hunger. Since 2010, the collaboration between Freedom from Hunger and the Microcredit Summit Campaign and their efforts to create a global alliance to link the health and microfinance sectors has enabled the further dissemination and extension of this work and has strengthened the message of its importance for the global goal of ending poverty. We are especially grateful to the many pioneering microfinance, self-help group and savings group partners around the world, and even more so to the millions of women who engage tirelessly in these efforts with the hope of healthier lives for themselves, their families and communities.

Freedom from Hunger, Davis, California
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Additional resources on health and microfinance can be accessed at
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Table of Contents

Executive Summary

Despite progress towards the Millennium Development Goals—including some notable improvements in health systems, health indicators and financial inclusion—1 billion people still live in poverty worldwide. Poverty and ill health go hand in hand, and just as a lack of resources often impedes poor people's ability to live healthfully and access timely health care, so too does ill health prevent people from generating regular income and making optimal use of inclusive financial services. Yet existing health solutions simply are not reaching enough people. The global health sector possesses and continues to enhance a vast store of proven, life-saving knowledge and tools, yet one of the sector's most pressing challenges is efficiently distributing these solutions to the people who need them most.

Meanwhile, the rapid growth and development of the microfinance sector throughout the developing world has led to an extensive, financially sustainable network comprising more than 350 million poor people who regularly interact with a trusted group or institution. As the sector's efficiency, sophistication and competition has grown, its appetite for complementary services has also increased. Given the central role that health plays in the lives of clients, more of these organizations and their stakeholders are seeking practical and sustainable ways to meet people's health-related educational, financial and access needs.

Freedom from Hunger in collaboration with the Microcredit Summit Campaign and other partners, is currently working with 29 MFIs, self-help promoting institutions (SHPIs) and non-governmental organizations (NGOs) that facilitate savings groups that collectively reach more than 2.7 million clients with health education, health loans, health savings, microinsurance and health care provider linkages, among other vital health-related services. This experience has generated evidence of relatively low program cost and positive impact on multiple stakeholders: poor women clients, the financial institutions themselves, health care providers and communities.

Integrated microfinance and health protection products can be remarkably inexpensive for MFIs to offer at scale. Analysis of costs and benefits of integrated health programs with a pilot group of five MFIs in 2009 revealed that the average annual net marginal cost of a range of integrated programs one to two years after product launch was US$.29 per client served, and the average total net cost (including allocated staff and overhead) was an annual $1.59 per client (Reinsch, Dunford, Metcalfe 2011). Follow-up analysis of three of the original MFIs, based on total reported program costs in 2013 showed even lower per-client costs—from an average of $1.12 in total costs per client per year to $.69 per client per year. MFIs also realize important indirect benefits that enhance their ability to retain clients and grow, and that support measureable social performance.

Research has shown that these programs are having significant, positive impacts on client-, household- and community-level health, while they also bolster health systems themselves. In Bolivia, 24 percent of clients participating in CRECER's health fairs had never previously visited a professional health care provider; in the Philippines, CARD's linkage, financing and educational outreach has led to increased enrollment in the national health microinsurance scheme; and in India, Bandhan's community-level health education and sale of ORS has increased appropriate treatment of diarrhea in children from 60 to 100 percent—which based on UNICEF estimates may well have saved the lives of thousands of children. By collaborating with MFIs, SHPIs and NGOs to extend their messages, products and services through existing and self-sustaining networks, public and private health care providers can expand their outreach exponentially at a very low cost.

Linking the widespread, financially sustainable delivery mechanism of microfinance with proven health structures and solutions represents a visionary, multisectoral opportunity to dramatically extend global health outreach while reinforcing the positive outcomes of financial inclusion. Ongoing investments are

needed to more fully engage the health sector; to continue to build the evidence base on impact and value; to provide additional opportunities for shared learning and advocacy; and to identify a broader range and depth of financing to support greater replication and scale. Sustained efforts in these key areas will support the extension and scale of linked health and financial services programs that offer significant opportunity to achieve catalytic and lasting change in the lives of poor people around the world.

The Challenge

Despite progress, poverty and preventable disease persist

Significant progress towards the Millennium Development Goals has been made globally, reducing extreme poverty and hunger, child and maternal mortality, and the burden of HIV/AIDS and malaria, and increasing access to water and sanitation. However, progress has been uneven. One billion people still live in extreme poverty with associated health risks, including avoidable morbidity and mortality, as well as persistent under-nutrition and malnutrition (WHO Countdown Report 2013). Poor health and malnutrition remain both symptoms and causes of poverty. While the development of new vaccines and technologies is one promising avenue for ongoing investment, the basic challenge of reaching people with proven health solutions—no matter how simple or high tech—is an important key to achieving catalytic change.

Health issues erode the impact of economic-strengthening efforts

Economic-strengthening efforts have made tremendous inroads within poor and isolated communities over the past few decades. Microfinance institutions (MFIs)[1] in their various forms currently reach hundreds of millions of people with safe places to save, appropriate loan sizes and terms, increasingly more efficient and convenient access via mobile phones, complementary business and financial training, and valuable risk protection. Yet microfinance clients and institutions alike cite health as a major barrier to overcoming poverty. MFIs report that ill health is a major contributor to client loan delinquency and negatively affects capacity to save and ability to weather financial shocks. Freedom from Hunger found that 11 to 48 percent of women microfinance clients have used enterprise loans for health expenses (Kobishyn 2009), and a study by PlaNet Finance found that 67 percent of clients with a microloan had an episode of malaria during their loan cycle, and fully 73 percent of those experienced repayment problems (Deszo 2013).

Women and children are especially impacted

Women and children shoulder a particularly heavy burden when it comes to poverty and ill health. Despite their usual role as primary caregivers within the household, poor women too often lack complete information about how to prevent and manage common diseases. Frequently, they also lack knowledge of, access to or ability to advocate for appropriate nutrition and healthcare services for themselves and their children. When illness strikes family members, women are often called upon to take time and even capital away from their income-generating activities to provide care and cover healthcare expenses—further eroding the household's ability to improve its financial status. Furthermore, childhood malnutrition and disease can impact children's physical and mental growth and schooling, thereby influencing their later health and economic prospects as adults (Belfield 2013).

Proven health solutions are not reaching enough people

Cost-effective and proven solutions exist to prevent or minimize serious consequences from pregnancy, childbirth and common childhood disease. Yet poor and low-income women and children still suffer and die needlessly because these interventions are not reaching them. Efforts at health-system strengthening are slow to resolve inequities caused by poverty, geography and gender. Most developing countries remain challenged

1. We have opted to use the term "microfinance and MFIs (microfinance institutions) " as a broadly inclusive term in this document to refer to the sector and practice also known as "inclusive finance", "financial services for the poor" and "financial access," among others. We view microfinance as encompassing financial services provided to people (especially poor women) via banks, MFIs, SHPIs that support self-help groups (SHGs), NGOs that facilitate savings groups and other supporting institutions.

to foster and sustain usage rates of simple, yet lifesaving interventions such as use of oral rehydration solution (ORS), timely treatment of childhood diarrhea and pneumonia, completion of tuberculosis treatment, adequate pre-/postnatal care with skilled birth attendance and exclusive breastfeeding (Bhutta, Black 2014).

The Opportunity

Microfinance presents an under-utilized distribution mechanism

The microfinance sector now represents an established and largely self-sustaining platform that plays a vital role in poor people's—especially women's—ability to create livelihoods, expand income-generating activities, smooth consumption and reduce their families' vulnerability to financial shocks. In many microfinance models, groups of clients gather regularly to learn about financial and business concepts, support each other, improve economic and other behaviors, and access a range of services. And the sector's client and social networks are vast. According to the Microcredit Summit Campaign's 2013 survey, MFIs are reaching 204 million clients, of which 116 million were among the poorest at the time of their first loan (Reed 2014). With its extensive and efficient distribution network, the microfinance sector holds tremendous value as a point of sustained contact and trusted influence with hundreds of millions of poor people across the developing world.

Gates-seeded innovation project showed proof of concept and potential for scale

The Bill & Melinda Gates Foundation funded an innovation initiative at Freedom from Hunger from 2006–2010 to test the hypothesis that MFIs could successfully serve as a distribution platform for a range of health-related products and services. The *Microfinance and Health Protection* (*MAHP*) initiative partnered with five MFIs in Africa, Asia and Latin America to develop and test the delivery of health education, health loans, health savings, health microinsurance, health product distribution and health care via provider linkages. The resulting health protection programs involved a variety of partnerships and linkages between MFIs and the local public health system, private providers, national insurance schemes and other actors. Toward the end of the initiative in 2009, the five *MAHP*-partner MFIs were reaching about 300,000 clients combined; since then, four of the five programs have continued to significantly scale up after the grant period, reaching almost 2.5 million by the end of 2013 (See Table 1). Taking family members into account, the benefits of these programs are currently reaching about 13 million people.

Table 1. Freedom from Hunger partner microfinance and health outreach 2009–2013

Country/Region	Microfinance and Health Outreach December 2009	Microfinance and Health Outreach December 2013
Andes	26,287	184,293
India	51,900	563,457
Southeast Asia	152,334	1,650,705
West Africa	71,036	167,319
Total	301,557	2,565,774

In 2010, Freedom from Hunger and the Microcredit Summit Campaign joined forces to provide technical assistance to partners in India to model and demonstrate what can be achieved on a global scale. A year later came the idea for a global alliance that would provide access to an international team of microfinance, health, and development practitioners, researchers and policy makers working with microfinance organizations around the world to implement and test innovative approaches to address poverty.

Support from Johnson & Johnson has enabled work with multiple MFIs, SHPIs, NGOs and state government partners in India to reach more than one million poor women, adolescent girls and their families. The partnership between Freedom from Hunger and the Microcredit Summit Campaign also plays an important facilitating and convening role that has brought together financial service practitioners, health providers, government officials, researchers, social investors, policymakers and donors through several workshops and roundtables, and has conducted analyses of the microfinance and health landscapes in India (2012 and 2014) and the Andes Region (2012).

A range of health-related services can be practically delivered through MFIs

Integrated health and microfinance programs may include different combinations of the following services.

Health education

- Interactive sessions on prenatal health, safe birth, nutrition, common childhood illnesses, malaria, HIV/AIDS, non-communicable disease prevention and water and sanitation
- Training on coping with health-related financial shocks, planning ahead to face common health expenses and getting the most out of local healthcare services and health microinsurance
- E-learning and mobile messaging to support behavioral change.

Health financing and microinsurance

- Health loans
- Health savings
- Loans for health insurance premiums and linkages to health microinsurance
- M-banking and mobile money to reduce transaction costs and client wait times to access health funds and services

Linkages to health providers

- Organization of mobile health services with public and private providers to deliver preventive and diagnostic services in rural areas
- Development of networks of providers who agree to provide a range of services for fixed or discounted prices
- Referrals to private and public providers for secondary care
- Prepaid-care programs with discounted primary care for rural clients
- Electronic card-based payments for health services
- Telemedicine access based in primary-care centers to provide lower-cost access to specialists for rural clients

Access to health products

- Door-to-door visits by trained and supervised village entrepreneurs who reinforce health education, sell health products and medicines such as ORS, de-worming medications, and drinking water treatment methods, and provide referrals to local healthcare providers
- Microfranchise distribution of affordable, essential drugs

Health-microfinance linkages are enhancing health-sector outcomes

Results from a wide range of studies, methods and contexts indicate positive impacts on client health knowledge, behaviors and access to health services following participation in integrated health and microfinance programs. These findings, which are consistent with a broader review of global evidence from other settings and implementers (Leatherman, Metcalfe 2012), are summarized in Table 2. Examples of specific outcomes at the level of clients/households, broader community and health providers/systems are presented below.

Table 2. Type of health intervention and benefit achieved*

Intervention	Client knowledge	Health behavior	Use of health service	Client health outcome	Health system capacity
Health education/promotion	X	X	X	X	X
Health clinic and trained community workers	X	X	X	X	X
Linkages to community providers	X	X	X		
Microinsurance			X		
Microloans to health providers			X		X

**Leatherman S, M Metcalfe, K Geissler & C Dunford. Integrating microfinance and health strategies: Examining the evidence to inform policy and practice. Health Policy and Planning. 2011.*

Client and household level

The direct benefits to poor families from improved access to information, health services and health financing that their MFIs can deliver have been increasingly documented (Leatherman, Metcalfe 2012). For improvements in access alone, the data from Bolivia and India are compelling. In Bolivia, 24 percent of clients participating in CRECER's regional health fairs had never previously seen any kind of formal health care provider (Metcalfe, Leatherman 2012); and in India, 33 percent of clients who used health loans indicated they would have delayed or foregone treatment without the loan. Similarly, in Burkina Faso, the percentage of RCPB clients who reported using preventive services (such as vaccinations, prenatal visits, blood pressure and diabetes screening and general checkups) went from 9 to 24 percent after a program of health education, health savings and health loans were introduced.

Moreover, rigorously controlled research shows that participation in MFI-facilitated health education increases health knowledge and has positive impact on key health behaviors related to maternal and child health and nutrition. For example, Table 3 illustrates findings from a longitudinal study of women at Bandhan, India for self-reported maternal and child health knowledge and behaviors pre-program, one year after program initiation and then four years later (with continuing community health worker support). These findings are consistent with other research that strongly suggests benefits from integrated health and microfinance services, particularly when using participatory learning approaches in conjunction with women's groups (Manandhar et al. 2004; Tripathy et al. 2010; Lewycka et al. 2013; Fottrell et al. 2013).

Table 3. Longitudinal study of changes in client-reported health knowledge and behaviors, Bandhan, India 2008–2013

Characteristics	Pre-Test 2008	Post-Test 2009	Follow-up 2013
Infant Feeding and Nutrition			
Percentage who knew how soon after birth a child should be breastfed	71	97*	92*
Percentage who knew to add oil, protein or vegetables to first foods for baby in order to make them more nutritious	93	96	98
Percentage whose child or children in their care was breastfed immediately or within one hour of birth (women with children<12 months)	61	93*	75
Percentage who reported introducing complementary foods at age six months or older (with children<12 months)	60	88*	100*
Diarrhea Treatment			
Percentage with a child in their household or care who had diarrhea in the last three months who treated that child with ORS	60	88*	100*
Prenatal and Maternal Health			
Percentage who were pregnant within the prior 18 months who received a referral from the MFI community health worker for prenatal care	31	38	64*
Percentage who gave birth during the past 12 months and were visited by an MFI community health worker within 48 hours of birth	16	36*	54*
Percentage who were pregnant within prior 18 months with at least three visits to a medical professional	87	86	95

**Indicates statistically significant difference between pre-test and post-test and/or follow-up surveys of at least p<.05*

Broader community

While microfinance infrastructure provides a large-scale platform for reaching large numbers of poor clients and their families, there is evidence of positive spillover into the larger community. Health education and other services delivered to groups and communities by MFIs, SHPIs and NGOs can improve knowledge, attitude and behaviors in nonparticipating households in the community. Published evaluations of health interventions through microfinance or community support groups for women provide evidence of positive externalities of such integration on nonparticipants (Smith 2002; Tripathy et al. 2010). For example:

- Freedom from Hunger's research using randomized control trials found evidence of more insecticide-treated bednets in communities in Bénin where malaria education was provided in credit groups (Gray, Ekoue-Kouvahey 2010).
- Women in Malian villages where malaria education was provided to savings groups demonstrated better understanding of the causes and prevention of malaria than women from control group villages (Final Impact Study Savings for Change 2009–2012).
- In the longitudinal study conducted by Freedom from Hunger with clients of Indian MFI Bandhan (see earlier reference), women were twice as likely to give advice to others in their communities on antenatal care, treatment of acute respiratory illness and diarrhea.

Such spillover effects can be substantial and thus demonstrate the transformative potential of a large-scale microfinance and health program.

Health providers and systems

Benefits to local health providers and systems are also important. Given their considerable market power, large MFIs are well positioned, in turn, to drive demand and direct clientele to selected providers, as well as to exert a positive influence on service quality. Examples of this include:

- In the Philippines, CARD has used its market power to organize a network of 1,500 health providers who have agreements with CARD to provide primary care, diagnostics, medicines and hospital services to hundreds of thousands of CARD clients and family members. Network providers deliver services at 10 to 40 percent below their regular fees, and report that they have seen the volume of patients increase.
- At CRECER in Bolivia, the health fairs described earlier provide enough volume for local private and public providers to cover all of their costs at a charge to clients and community members that is 50 percent below regular fees.
- Other providers in the Andes region such as the University of San Francisco de Quito and the Clinica Americana have worked with MFIs to develop provider networks and prepaid health-financing products that provide access to a range of primary-care services.

Public health systems also benefit from the opportunity to access and leverage the power of groups for achievement of outreach goals. MFIs and SHGs can play an important role in increasing client knowledge of available services and how to access them and strengthening public health system outreach. In numerous programs, local public healthcare workers regularly attend health education sessions and work with the MFIs to organize community-wide health-promotion and screening events. In India, the Government of West Bengal has contracted with Bandhan to support oral polio vaccine campaigns and DOTS tuberculosis programs using the MFI's network of community health workers. Enrolling the large informal sector in national health

insurance schemes has been an ongoing challenge in countries seeking universal insurance coverage. In the Philippines and in Ghana, MFIs have contributed to initiatives to increase uptake of national health insurance schemes by promoting enrollment (CARD and SAT), and facilitating registration, premium financing and remittance (CARD).

The programs are low cost

Direct costs of offering integrated health and microfinance programs

Integrated microfinance and health protection products can be remarkably inexpensive for MFIs to offer at scale. Cost and benefit analyses of the pilot group of five MFIs in 2009 revealed that the average annual net marginal cost of a range of integrated programs one to two years after product launch was US$.29 per client served, and the average total net cost (including allocated staff and overhead) was an annual $1.59 per client (Reinsch, Dunford, Metcalfe 2011). Follow-up analysis of three of the original MFIs, based on total reported program costs in 2013, showed even lower per-client costs—from an average of $1.12 in total costs per client per year to $.69 per client per year (Table 4)—possibly as a result of economies of scale and increased outreach. This is despite having expanded the types of health services provided. All three MFIs have simultaneously grown and strengthened their financial performance.

Table 4. Net cost per client of integrated health and microfinance programs (USD)

	2009 Costs Total w/allocated overhead	2013 Costs Total w/allocated overhead
Bandhan (India)*	(1.73)	(1.01)
CARD** (Philippines)	(.74)	(.27)
CRECER (Bolivia)***	(.88)	(.80)
Average	(1.12)	(.69)

**Bandhan program in 2013 includes the addition of six small primary-care centers.*

***CARD program includes the addition of 12 small health centers and expanded community health outreach with regular screening and service fairs in local communities.*

****CRECER program includes a new campaign to screen and diagnose cervical cancer with multi-day screening events in local communities.*

Compared to the per-client cost of similar health-related development interventions, the net costs of the integrated health and microfinance programs appear low. We examined published studies of roughly comparable health programs offered by other organizations (Table 5). Although the comparison is admittedly imprecise, it does offer some general benchmarks that suggest the integrated health and microfinance programs are cost-effective—perhaps because the health services are being delivered via existing, financially self-sustaining distribution mechanisms.

Table 5. Sample per-client costs of comparable health interventions not linked with microfinance

Intervention	Annual Per-client Cost (USD)
CARE Groups: Volunteer health promoters delivering health education (World Relief, Care Groups, Mozambique, 2003; Cambodia, 2007; Malawi, 2000; Rwanda, 2004)	$5.81*
Hygiene and sanitation education: Bangladesh (Mascie and Taylor 2003)	1.15**
Participatory women's groups—health education: Malawi (Lewycka et al. 2013)	$5.50***
ASHAs providing health education and home visits in Jharkhand, India (Roy and Mahapatra 2013)	1.78****
Group-based health education for sanitation: Zimbabwe (Waterkeyn and Cairncross 2000)	3.64*
Child health days in Ethiopia (Fiedler and Chuko 2008)	0.56
Distribution of vitamin A capsules (average costs in seven countries in Africa, Asia and Latin America) (Neidecker-Gonzales and Bouis 2007)	1.00

**Average across groups or countries in project*

***Average reported for 1 percent increase in knowledge of hygiene, water and sanitation*

****Average cost per woman of childbearing age*

*****Estimated based on per community meeting costs*

Tangible social net-value creation

The low annual per-client cost of running these programs is dwarfed by the positive social value that they create for microfinance clients and their communities. Here are three examples of the social and client value these investments achieve.

- In India, the annual number of deaths of children age 5 and under from diarrhea is estimated to be 334,000; and 12.3 children die for every 1,000 live births from diarrhea before their fifth birthday (Bassani et al. 2010). Using the average fertility rate in India (2.5), the women who are reached by Bandhan's program (over 400,000) will give birth to 1 million children during their lifetime, and unless something very important changes, 12,300 of these children will die from diarrhea by age 5. UNICEF estimates that the use of ORS would prevent 90 percent of diarrhea deaths in children. Prior to the implementation of their health program, 60 percent of Bandhan clients reported that they had treated a child with diarrhea with ORS; one year later, 88 percent reported ORS treatment; and five years later, 100 percent reported ORS treatment. Even with generous allowances for over-reporting and lack of a rigorous control study context, it is very likely that Bandhan's program is making an important contribution to saving thousands of lives of very young children each year from diarrhea alone, from a program that costs about $1 per family per year for Bandhan to operate.
- Analysis of costs at CRECER in Bolivia indicated that CRECER saves women who participate in their health days (clients and community members who are not clients) 50 percent off of a cervical cancer screening and diagnostic package. When total costs of the program are compared to the savings for women, CRECER creates $11 of savings for the community for every $1 invested in the health program.

- A recent study conducted internally by Indian MFI Equitas senior leadership indicated that clients spend up to 25 percent of their meager income on health-related costs, and that Equitas with its negotiated provider network generates 25 INR (Indian Rupees) of client value or savings for every 1 INR invested by Equitas in its health program.

Microfinance sector demand for complementary services is growing

Over recent years, a number of factors have led to a growing interest on the part of many microfinance investors, practitioners and clients in the addition of nonfinancial services to complement financial offerings. Whether due to concerns over mission drift, the growing efficiency and sophistication of the sector or MFIs' competitive positioning, more and more microfinance providers are seeking new, smart ways to add value to their financial services. Financial education and livelihood training are examples of increasingly popular complementary services that MFIs are successfully integrating. Although health is still on the frontier of this trend, Freedom from Hunger and the Microcredit Summit Campaign have assembled health and microfinance "communities of practice" in the Andes, India and the Philippines with the active participation of about 80 MFIs already committed to integrated health-related services.[2] This interest in adding value with complementary nonfinancial services makes sense and—given its prominence in people's financial lives—focusing on health is especially compelling.

Empirical data on the health status and spending of poor people in developing countries, corroborated with extensive market research conducted by Freedom from Hunger, indicate that ill health and related spending play an enormous role in the lives of MFI and SHG clients (Metcalfe and Reinsch 2008). MFIs frequently report that clients join, recommend and stay with their organization as a result of the complementary health-related services provided. While this data is anecdotal, it makes sense that many poor people would give extra consideration to joining an MFI or SHG offering a tool to help them manage their health. Likewise, existing clients may well remain longer with their MFI because they appreciate not only the service itself but also, potentially, the mere fact that the MFI seems to "care" about its clients' well-being.

Findings from *MAHP* cost-benefit analyses conducted in 2009 showed that if just 1 percent of the clients receiving health-related products had come to or stayed with the MFI as a result of these offerings, the average total net loss from the packages would have been offset by about 50 percent (from an overall average cost of $1.59 per client to $.74 per client per year). If as much as 5 percent of client attraction or retention were attributable to the products, then they would have more than paid for themselves and even contributed to net earnings (Reinsch, Dunford 2012). Thus while most MFIs report being driven primarily by social mission to provide integrated health-related products and services (Somen, Rao, Metcalfe et al 2014), there are also logical business reasons to invest time and resources to addressing clients' health protection.

The Way Forward

The large platform of 3,700 MFIs and 204 million clients, along with 6.8 million members of savings groups, offers a promising yet still vastly under-developed opportunity for leveraging the strengths of this network—its financially sustainable platform and established delivery channels—to reach many more of the world's poor with simple, proven and sustainable healthcare services. So what is needed to further develop and realize this opportunity? In our view there are a few key areas where collaborative and well-supported efforts are needed.

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2. For more information on these communities of practice and the growing interest in integrated health and microfinance programs, see State of the Field reports for India and the Andes region. (Microfinance & Health Protection Documents | Freedom from Hunger)

Full engagement of the health sector

MFIs provide an opportunity for both public and private health providers to improve and sustain service outreach in rural and hard-to-reach areas. Yet to date, most of the integrated health and financial services work has been initiated and developed by MFI practitioners. Higher priority must be given to understanding how to develop partnerships that address the objectives and limitations of both public and private health providers and MFIs to leverage their respective strengths; and to the development of expertise to create successful and large-scale alliances.

Stronger evidence base for impact and cost-effectiveness relative to other delivery channels

Evidence from current programs that link health and MFIs is indeed promising, yet perhaps still insufficient to motivate the shifts in thinking, practice and policy that are needed to reach substantially more poor women clients. Much of the published research on integrating microfinance and health is limited due to single project data, weak research methods and the absence of health outcome measures. Monitoring and analysis of program investment needs and costs require tracking over longer periods and across a greater diversity of programs, interventions and contexts. Established and emerging programs offer rich opportunities for additional and more rigorous research to further explore questions related to health outcomes and costs and scalability of programs, and to further strengthen the evidence base across multiple contexts.

Opportunities for sharing and dissemination

The number of integrated health and microfinance programs and practitioners is growing. Early implementers are reaching scale and pushing the innovation envelope with programs that address the growing threat to the poor of non-communicable or chronic diseases; with new approaches to health financing; and with the introduction of mobile technology to reduce costs and increase scale at low cost. These practitioners have many important lessons and tools to share with others, saving time and costs for new entrants to accelerate replication and scale. Nascent learning communities of practitioners in the Andes, India and the Philippines are providing forums to convene health and MFI stakeholders as well as policymakers and investors at the regional and national levels. These groups are sharing lessons learned, results, agendas for advocacy to create more enabling environments, and in some cases resources for program development and they should be supported, strengthened and extended to other regions such as Africa and South East Asia.

Addressing regulatory challenges

The rapid growth of the MFI sector, the entry of many new players and the claims of negative outcomes of microfinance on clients as shared in the press, have put regulation of the sector high on the agenda of governments, investors and the MFIs themselves. There is concern that instead of access and use of credit alleviating or even reducing poverty, it is creating debt burdens that drive families into even deeper poverty and hopelessness. The primary and important objective of good regulation is client protection and the prevention of predatory lending practices. However, missing from the discussion of regulation, particularly related to interest-rate caps, are the possible unintended consequences for MFIs that provide health, financial literacy education and other services as a part of a broad strategy of poverty reduction. Regulations that severely limit or preclude the provision of services in addition to credit, even when those services directly or indirectly contribute to a client's well-being and ability to sustain a livelihood, will not help or protect poor families. Further, a growing number of MFIs are demonstrating that client protection, transparency in pricing and the provision of a range of services that reach the poor and improve their lives are mutually reinforcing.

CRECER in Bolivia has been recognized by the SMART Campaign and TrueLift for having achieved the highest rankings in client protection and pro-poor services. To achieve these levels of recognition an organization must demonstrate not only that its credit products and processes are client centered and transparent, but also provide evidence of outreach to and positive impact on poor clients. At CRECER, these achievements have been accomplished while remaining financially vibrant in an increasingly competitive market and alongside the provision of a health program that reaches over 100,000 women. Good regulation cannot be at the expense of programs such as CRECER's and those of other MFIs that are helping microfinance clients attain better lives and at the same time also increasing their capacity to successfully participate in financial services.

Expanded range of financing and support for development and scale

The development, implementation and evaluation of any new program require significant upfront resources. The experience of Freedom from Hunger and the Microcredit Summit Campaign has shown that MFIs can and will invest internal resources to cover part of the start-up costs associated with new, integrated health and microfinance programs. Our MFI partners have contributed about $30,000 on average for a typical two- to three-year launching period. But the majority of implementing MFIs require smart subsidies as well as some technical assistance to facilitate timely pilot tests and to roll out successful products to reach minimally sustainable scale. A strong case can and should be made for ongoing donor support and especially as the health and financial services model is extended to poorer, more financially excluded women through linkages with savings-led initiatives. Other approaches recognize and target the value of these programs as social investments with potential for important long-term returns. A social investment approach that provides needed capital to MFIs for program operations and on-lending can be structured to target programs with a strong commitment to improved health and welfare of its clients, and coupled with needed technical assistance and robust indicators of performance. Expected returns on these investments include improved client loyalty, retention and measureable social performance for MFIs; greater outreach to fulfill mandates for public health providers and market share for private providers; and improved health and capacity to participate in financial services for improved income and food security for poor families.

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